

Council on Medical Student Education in Pediatrics (COMSEP) Member Application Form

Membership in COMSEP is offered to educators or physicians who have an interest in pediatric undergraduate medical education.

Please include a copy of your CV with the application and the membership fee of **\$100.00**.

Please make check payable to COMSEP and return to:

6728 Old McLean Village Drive
McLean, VA 22101
Phone: 703-556-9222 Fax: 703-556-8729

Name: _____

Title: Clerkship Director (Years in Position: _____)
 Associate Clerkship Director (Years in Position: _____)
 Other (Please specify: _____)

Current Medical School: _____

Mailing Address: _____

Email Address: _____

Work Phone: _____ Fax Number: _____

Education/Professional Information:

Degree (s): _____ Academic Rank: _____

Subspecialty: _____

Years in Professional Role: _____ Other Title (s): _____

Interests in COMSEP (Check all that apply):

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Research/Scholarly Activity | <input type="checkbox"/> Curriculum |
| <input type="checkbox"/> Evaluation | <input type="checkbox"/> Technology |
| <input type="checkbox"/> Faculty Development | <input type="checkbox"/> OSCE, etc. |
| <input type="checkbox"/> Other: | |

For Office Use Only:

Received: _____ Check Number: _____

Check Date: _____ Check Amount: _____

Entered in Database: _____ Updated Listserv: _____

Date and Initials

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